



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
P.O. Box 11729  
Albany, NY 12211

## Notice of Decision

Decision Date: June 30, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016987

[REDACTED]

Dear [REDACTED],

On June 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 17, 2016 eligibility determination notice, November 23, 2016 disenrollment notice, December 12, 2016 eligibility determination notice and December 12, 2016 enrollment notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

### Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY - Spanish: 1-877-662-4886).

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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
P.O. Box 11729  
Albany, NY 12211

## Decision

Decision Date: June 30, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016987

[REDACTED]

## Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Was your appeal of NY State of Health's November 17, 2016 eligibility determination, November 30, 2016 disenrollment notice, December 12, 2016 eligibility determination notice and December 12, 2016 enrollment notice timely?

Did NY State of Health properly determine that your eligibility for and enrollment in Medicaid and your Medicaid Managed Care plan ended November 30, 2016?

Did NY State of Health properly determine that you were eligible for the Essential Plan, effective January 1, 2017, and not eligible for Medicaid?

Did NY State of Health properly determine that your enrollment in an Essential Plan was effective January 1, 2017?

## Procedural History

On December 31, 2015, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid, effective December 1, 2015.

Also on December 31, 2015, NYSOH issued a notice of enrollment confirmation stating that your enrollment in your Medicaid Managed Care plan was effective as of February 1, 2016.

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On October 9, 2016, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by November 15, 2016 or you might lose the financial assistance you were currently receiving.

No updates were received by November 15, 2016 and NYSOH redetermined your eligibility for financial assistance with health insurance.

On November 17, 2016 NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. Your eligibility ended November 30, 2016.

On November 23, 2016, NYSOH issued a disenrollment notice stating that your coverage with your Medicaid Managed Care plan would end on November 30, 2016.

On December 11, 2016, you updated your application for financial assistance with health insurance through NYSOH.

On December 12, 2016, NYSOH issued a notice of eligibility determination, based on your December 11, 2016 application, stating that you were eligible to enroll in the Essential Plan, effective January 1, 2017.

Also on December 12, 2016 NYSOH issued a notice of enrollment, based on your plan selection on December 11, 2016, stating that you were enrolled in an Essential Plan, and that your plan would start January 1, 2017.

On March 20, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in the Essential insofar as it did not begin December 1, 2016 or in the alternative, that you did not have Medicaid for the month of December 2016.

On June 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for fourteen days to allow you time to submit income documentation. On June 19, 2017, the Appeals Unit received via fax copies of your paystubs from December 2016.

## Findings of Fact

A review of the record supports the following findings of fact:

- 1) You testified that you are seeking either to have Medicaid for the month of December 2016 or to have your Essential Plan begin on December 1, 2016. This is because you have outstanding medical bills for that month.
- 2) You testified, and the record reflects, that you first became eligible for Medicaid through NYSOH as of December 1, 2015.
- 3) You testified, and the record reflects, that you receive all of your notices from NYSOH by regular mail.
- 4) Your NYSOH account indicates that you updated your mailing address on December 10, 2016.
- 5) Your NYSOH account indicates that your previous address was [REDACTED]
- 6) You testified that as of December 1, 2016 your address is [REDACTED]
- 7) You testified that you did not receive the October 9, 2016 renewal notice telling you that you needed to update your application in order to renew your eligibility for financial assistance until January 2017. You also testified that you did not receive the November 17, 2016 eligibility determination until January 2017. You further testified that you never received the November 23, 2016 disenrollment notice.
- 8) The October 9, 2016 renewal notice was mailed to the [REDACTED]. This notice was not returned as undeliverable.
- 9) The November 17, 2016 eligibility determination was returned to NYSOH by the United States Postal Service marked as "not deliverable as addressed, unable to forward".
- 10) You testified that you went to the doctor on [REDACTED] and were not advised at that time that you did not have coverage. You explained that it was shortly after this appointment that you learned that your Medicaid coverage had ended.
- 11) You submitted an application to NYSOH for financial assistance on December 11, 2016.

- 12) The record reflects, that you enrolled in an Essential Plan on December 11, 2016.
- 13) On December 12, 2016, you filed a complaint ( [REDACTED] ) wherein you requested to either have your Essential Plan backdated or to have your Medicaid coverage extended for the month of December 2016.
- 14) You testified that you did not request a formal appeal until March 20, 2017, as you were directed to contact your health plan directly, and were advised that an appeal would not change anything. You thereafter contacted your plan and were advised that you would need to file a formal appeal with NYSOH in order to pursue coverage for December 2016.
- 15) You testified that you expect to file your 2017 federal tax return as single and will claim no dependents on that return.
- 16) The application that you submitted on December 11, 2016 listed annual expected household income of \$23,204.00. You testified that this was correct.
- 17) You testified that in December 2016 you were working two part-time jobs. You testified that you believe that you only received one paycheck for December 2016 from one of your jobs.
- 18) You submitted four paystubs from one of your employers; the first is for pay date December 9, 2016 for a gross pay amount of \$499.40; the second is for pay date December 16, 2016 for a gross pay amount of \$275.55; the third is for pay date December 23, 2016 for a gross pay amount of \$445.78; the fourth is for pay date December 30, 2016 for a gross pay amount of \$499.60. You submitted one paystub from the other of your employers for pay date December 23, 2016 for a gross pay amount of \$640.00.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## **Applicable Law and Regulations**

### Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45

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CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

### Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is \$11,880 for a one-person household (81 Fed. Reg. 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

### Medicaid Continuous Coverage

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

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An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

### Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid Managed Care (MMC) plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H(6)(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

### Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR



§ 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is \$11,880.00 for a one-person household (81 Fed. Reg. 4036).

A person who has a household income that is at or below 150% of the FPL has a \$0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a \$20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (see 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

### Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); see *also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

## **Legal Analysis**

The first issue is whether your appeal of NYSOH's November 17, 2016 eligibility determination, November 30, 2016 disenrollment notice, December 12, 2016

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eligibility determination notice and December 12, 2016 enrollment notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding your Medicaid coverage for December 2016 as well as your Essential Plan start date on March 20, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the due date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of the disenrollment from your Medicaid, an appeal should have been filed by January 16, 2017. For an appeal to have been valid on the issue of the start date of your Essential Plan, an appeal should have been filed by February 10, 2017. The record reflects that you filed your appeal on March 20, 2017, which is beyond the 60-day deadline.

Although the appeal was untimely on its face, the record reflects that you contacted NYSOH and filed a complaint on December 12, 2017, which was within the 60-day deadline. You also explained that you were referred by NYSOH directly to your plan, and it was your plan that advised you that you would need to file a formal appeal in order to address coverage for December 2016. As you filed a complaint within the 60-day deadline, and the subject of the complaint is the same as the appeal, the appeal is considered timely and will be addressed.

The second issue is whether NYSOH properly determined that your eligibility for and enrollment in Medicaid and your Medicaid Managed Care plan ended November 30, 2016.

You were originally found eligible for Medicaid effective December 1, 2015.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's October 9, 2016 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by November 15, 2016, or your financial assistance might end.

You testified that you did not receive the October 9, 2016 renewal notice from NYSOH telling you that you needed to update the information in your NYSOH account until January 2017. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. The October 9, 2016 renewal notice was sent to the [REDACTED] address, which you testified was your address at that time. There

have subsequently been notices that were returned as undeliverable due to your changing residences at the end of November 2016, but there is no evidence in the record that the October 9, 2016 renewal notice was returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated in order to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

Because there was no timely response to this notice and your 12-months of Medicaid coverage had run out, NYSOH properly terminated you from Medicaid and your Medicaid Managed Care plan effective November 30, 2016.

Therefore, the November 17, 2016 eligibility determination and the November 23, 2016 disenrollment notices are AFFIRMED.

The third issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective January 1, 2017, and ineligible for Medicaid.

You testified that you file your tax return with a tax filings status of single and claim no dependents. Therefore, you are in a one-person household.

The application that you submitted on December 11, 2016 listed annual expected household income of \$23,204.00 and the eligibility determination relied on that information.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$11,880.00 for a one-person household. Since an annual household income of \$23,204.00 is 195.32% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$11,880.00 for a one-person household. Since \$23,204.00 is 195.32% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

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You submitted paystubs that show in December 2016 you received \$2,360.33.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,367.00 per month. Since the documentation you provided shows that you earned \$2,360.33 in December 2016 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the December 12, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

The fourth issue is whether NYSOH properly determined that your enrollment in the Essential Plan was effective January 1, 2017.

You testified, and the record indicates, that you updated your NYSOH application on December 11, 2016. As a result, you were found eligible for the Essential Plan as of January 1, 2017 and enrolled into a plan that day.

The date on which enrollment in an Essential Plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

On December 11, 2016, you selected an Essential Plan, so your enrollment properly took effect on the first day of the first month following December 2016; that is, on January 1, 2017.

Therefore, the December 12, 2016 enrollment confirmation notice stating that your enrollment in the Essential Plan was effective January 1, 2017, is correct and must be AFFIRMED.

## **Decision**

The November 17, 2016 eligibility determination is AFFIRMED.

The November 23, 2016 disenrollment notice are AFFIRMED.

The December 12, 2016 eligibility determination is AFFIRMED.

The December 12, 2016 enrollment confirmation notice is AFFIRMED.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

**Effective Date of this Decision:** June 30, 2017

## **How this Decision Affects Your Eligibility**

This decision does not change your eligibility.

Your eligibility for Medicaid ended as of November 30, 2016.

Your enrollment in Medicaid and your Medicaid Managed Care plan ended November 30, 2016.

You remain eligible for the Essential Plan.

You are not eligible for Medicaid.

The effective date of your Essential Health Plan is January 1, 2017.

## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

Health Insurance Marketplace  
Attn: Appeals

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465 Industrial Blvd.  
London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

### **If You Have Questions about this Decision (Customer Service Resources):**

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

### **Summary**

The November 17, 2016 eligibility determination is AFFIRMED.

The November 23, 2016 disenrollment notice are AFFIRMED.

Your eligibility for Medicaid ended as of November 30, 2016.

Your enrollment in Medicaid and your Medicaid Managed Care plan ended November 30, 2016.

The December 12, 2016 eligibility determination is AFFIRMED.

This decision does not change your eligibility.

You remain eligible for the Essential Plan.

You are not eligible for Medicaid.

The December 12, 2016 enrollment confirmation notice is AFFIRMED.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

The effective date of your Essential Health Plan is January 1, 2017.

### **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

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**A Copy of this Decision Has Been Provided To:**





## **Getting Help in a Language Other than English**

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

### **Español (Spanish)**

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

### **中文 (Traditional Chinese)**

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

### **Kreyòl Ayisyen (Haitian Creole)**

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

### **中文 (Simplified Chinese)**

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

### **Italiano (Italian)**

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

### **한국어 (Korean)**

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

### **Русский (Russian)**

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

### **العربية (Arabic)**

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

### **বাংলা (Bengali)**

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### **Français (French)**

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

### **हिंदी (Hindi)**

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

### **日本語 (Japanese)**

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

### **नेपाली (Nepali)**

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

### **Polski (Polish)**

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

### **Twi (Twi)**

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. y&b&tumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

### **(Urdu) اردو**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

### **Tiếng Việt (Vietnamese)**

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

### **שׂוֹדִישׁ (Yiddish)**

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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